Remarks at ABC's "Prescription for America" Townhall Meeting and a Question-and-Answer Session

June 24, 2009

Charles Gibson. Good evening. Diane and I are delighted that you could join us this evening. We are going to be talking about what will be the number-one subject for public discourse all through this summer, and that is health care reform.

Diane Sawyer. The President has said it's a ticking time bomb at the center of the American economy. And so we have gathered 164 people in the East Room of the White House tonight. They're from all over the country, all walks of life, on the frontlines of health care in America; they are doctors, businessmen, patients, Republicans, Democrats, independents. And we know we can't cover every question tonight, but we're going to get the conversation started.

Mr. Gibson. They will be questioning the President, as will we. And we think by the end of the evening you will have a pretty good sense of what the parameters of this debate are, just what's at stake for each of you and for the country as a whole, because this will be discussed, as we said, all through the summer in the Congress. It will be discussed, I think, also in your living room. Every family I think will be debating this.

So with that as preface, we want to thank the President for giving us his parlor and his living room tonight to do this broadcast.

The President. Thank you so much, Charlie. It's wonderful to see you.

Mr. Gibson. Mr. President, I think this is going to be an interesting evening.

The President. Thank you so much, Diane.

Ms. Sawyer. Mr. President, thank you.

The President. Grateful to have you.

Ms. Sawyer. While we head into the East Room, we're going to have the audience waiting for us there. Dr. Tim Johnson, who is our medical editor, is going to give everyone a sense of some of the key questions. We're heading to the East Room.

The President. All right.

[*At this point, there was a break in the townhall meeting.*]

Dr. G. Tim Johnson. First, access and choice: The President constantly stresses that if you like what you have, you can keep it. But he also wants to offer more choice and competition with a one-stop shopping list of approved private insurance plans through a so-called Health Insurance Exchange. So far, he has also insisted that a public option be one of the choices. It has sometimes been described as Medicare-like, meaning the Government would be involved with the financing, but patients would be able to choose their own doctors and hospitals.

He says this public option would keep the pressure on private insurance to hold down costs. Critics say Government's advantages—easy funding, huge bargaining power—would eventually put private insurers out of business, which could affect your current coverage.

Second, effective treatment: The President agrees with experts who say that about a third of what we now spend on health care is unnecessary. He says we reward doctors and hospitals the wrong way, paying for simply doing more tests and procedures, rather than paying for good outcomes. And he stresses that primary care—readily available family doctors, physician assistants, and nurse practitioners—is essential in promoting prevention, making sure we get screening tests and lifestyle advice, and coordination, orchestrating the care of specialists and home care for chronic diseases.

Critics say that if third-party Government experts set the rules for what is covered and paid for, patients and doctors will have less of a voice and choice.

And finally, cost control: The President insists that increasing coverage without controlling costs is a formula for economic disaster. That would be a tough job, given that estimates for reform now run between one and two trillion dollars over 10 years. Besides savings from the reform of Medicare and Medicaid, he has advocated new tax revenue by limiting deductions for charitable giving, but he has not yet agreed to taxing any insurance benefits from employers as income.

Critics say his plan spends too much and the Government just does not have the money. So, Diane and Charlie, three huge challenges, a formula for heartburn, which, by the way, is something we doctors can fix. [*Laughter*]

Mr. Gibson. Dr. Tim Johnson there, outlining some of the parameters of the debate. And we're going to try to loosely organize things. We have this—we're calling this "Prescription of America," but basically, this is: How does this affect me? How does it affect all of you at the doctor's office? Should there be a public option, public Government insurance in all of this? And what is the cost of all of this? Can we afford it?

And as we mentioned, 164 people here from all walks of life, Mr. President. Before we start, I'm curious, I want to get a show of hand. How many of you—whether you agree with the President's approach or not—how many of you agree that we need to change the health care system in America? And is there anybody here who believes the system should be left unchanged? Interesting. But there is a lot of disagreement, because the devil is in the details, as we all know.

The President. No, let's stop now. Let's go. We're ready to—[*laughter*].

Mr. Gibson. So as we say, all of this is: How does this affect me? And we want to get to your questions, and I want to start with Dr. Orrin Devinsky. Is he here? Dr. Devinsky.

Quality Health Care

Q. Yes, in the past, politicians who have sought to reform health care have tried to limit costs by reducing tests, access to specialists. But they've not been good at taking their own medicine. When they or their family members get sick, they often get extremely expensive evaluations and expert care. If a national health plan was approved and your family participated—and, President Obama, if your wife or your daughter became seriously ill, and things were not going well, and the plan physicians told you they were doing everything that reasonably could be done, and you sought out opinions from some medical leaders in major centers, and they said there's another option that you should pursue, but it was not covered in the plan, would you potentially sacrifice the health of your family for the greater good of insuring millions, or would you do everything you possibly could as a father and husband to get the best health care and outcome for your family?

The President. Well, first of all, doctor, I think it's a terrific question, and it's something that touches us all personally, especially when you start talking about end-of-life care. As some of you know, my grandmother recently passed away, which was a very painful thing for me. She's somebody who helped raise me. But she's somebody who contracted what was diagnosed as terminal cancer; there was unanimity about that. They expected that she'd have 6 to 9 months to life. She fell and broke her hip. And then the question was, does she get hip replacement surgery, even though she was fragile enough that they weren't sure how long she would last, whether she could get through the surgery?

I think families all across America are going through decisions like that all the time. And you're absolutely right that if it's my family member, if it's my wife, if it's my children, if it's my grandmother, I always want them to get the very best care.

But here's the problem that we have in our current health care system, is that there is a whole bunch of care that's being provided that every study, every bit of evidence that we have, indicates may not be making us healthier.

Mr. Gibson. But you don't know what that test is.

The President. Well, oftentimes we do, though. There are going to be situations where there are going to be disagreements around—among experts. But oftentimes we do know what makes sense and what doesn't. And this is just one aspect of what is a broader issue.

And if I could just pull back just for a second, understand that the status quo is untenable, which is why you saw—even though we've got Republicans, Democrats, independents, people from all parts of the health care sector represented here, everybody understands we can't keep doing what we're doing. It is bankrupting families. I get letters every single day from people who've worked hard and don't have health insurance. It is bankrupting businesses who are frustrated that they can't provide the same kind of insurance that they used to provide to their employees. And it's bankrupting our government at the State and Federal levels.

So we know things are going to have to change. One aspect of it the doctor identified is, can we come up with ways that don't prevent people from getting the care they need, but also make sure that—because of all kinds of skewed incentives, we are getting a lot of quantity of care, but we're not getting the kind of quality that we need.

Overtreatment

Ms. Sawyer. I want to ask about this, Mr. President, because you said to me when we talked yesterday that you think if everyone has the right information, that doctors will make the right decisions, patients will make the right decisions, and you just said we think we do know what is overtreatment or not. Dr. John Corboy, from Colorado, do we always know? And what if a patient comes to you and says, "No, I want that extra CAT scan. I think I need that extra CAT scan," and you're at the risk of being sued, among other things? What are you going to do?

Q. Well, I think you still have to provide the appropriate care, and I think we all know that there is a significant amount of care that actually is inappropriate and unnecessary. And the question then is, for you, Mr. President, is what can you convince—what can you do to convince the American public that there actually are limits to what we can pay for with our American health care system? And if there are going to be limits, who is going to design the system, and who is going to enforce the rules for a system like that?

The President. Well, you're asking the right question. And let me say, first of all, this is not an easy problem. If it was easy, it would have been solved a long time ago, because we've been talking about this for decades. Since Harry Truman, we've been talking about how do we provide care that is high quality, gives people choices, and how can we come up with a uniquely American plan, because one of the ideological debates that I think has prevented us from making progress is some people say this is socialized medicine; others say we need a completely free market system. We need to come up with something that is uniquely American.

Now, what I've said is that if we are smart, we should be able to design a system in which people still have choices of doctors and choices of plans, that makes sure that the necessary treatment is provided but we don't have a huge amount of waste in the system, that we are providing adequate coverage for all people, and that we are driving down costs over the long term.

If we don't drive down costs, then we're not going to be able to achieve all those other things. And I think that on the issue that's already been raised by the two doctors, the issue of evidence-based care, I have great confidence that doctors are going to always want to do the right thing for their patients if they've got good information and if their payment incentives are not such that it actually costs them money to provide the appropriate care.

And right now what we have is a situation. Because doctors are paid fee-for-service and there are all sorts of rules governing how they operate, as a consequence, oftentimes it is harder for them, more expensive for them to do what is appropriate. And we should change those incentive structures.

Well-Managed Health Care Systems

Mr. Gibson. And people, I think, understand that you want to get away from quantity for quantity's sake, because that's the way the doctor makes more money, and get to quality. But the question is, how do you do that? How do you get to the point and still assure people—as both of the doctors have asked—that their cousins, their nephews, their husbands, their wives are going to get everything that is necessary?

The President. Well, let's take an example. And I—they may be represented here, I wasn't sure. But the Mayo Clinic, everybody has heard of it; it's got some of the best quality care in the world; people fly from all over the world to Rochester, Minnesota, in order to get outstanding care. It turns out that Mayo Clinic oftentimes provides care that is as much as one-third less expensive than the average that's provided or in—or some other health care systems that aren't doing as good of a job.

Now, why is that? Well, part of it is that they have set up teams that work together so that if you go first to your primary care physician and they order a test, you don't then have to duplicate having two more tests with other specialists because they were in the room when you first met with that primary care physician. They know how to manage chronic diseases in an effective way, so that we have people who are getting regular checkups, if they're trying to manage diabetes, as opposed to us paying for a $30,000 foot amputation because we didn't manage the disease properly.

So they are doing all kinds of smart things that we could easily duplicate across the system, but we don't. And our job in this summer and this fall—and which I think everybody understands we've got to move in a different direction—is to identify the best ways to achieve

the best possible care in a way that controls costs and is affordable for the American economy long term.

Government Involvement in Health Care

Ms. Sawyer. Mr. President, you mentioned Mayo Clinic—and I'm going to cross as I talk here, if you don't mind—but I've been reading a lot of the e-mail questions that we've been getting online. They've been saying the Mayo Clinic is exactly the point; they're doing it.

The President. Right.

Ms. Sawyer. Private industry is doing it. Private hospitals are doing it. The Safeway Company is taking action. Why get the Government involved in something that is being done already in the private sector and with the right initiative and impetus could be done in the private sector without Government involvement?

The President. Well, you just said with the "right initiative," and unfortunately, that initiative hasn't been forthcoming. And as a consequence, what's happening is—see, here's what happening to ordinary families—because I know one of those boxes was, "How does this affect you?"

The average family has seen their premiums double in the last 9 years. Costs for families are going up three times faster than wages. So if you're happy with your health care right now—and many people are happy with their health care right now—the problem is, 10 years from now, you're not going to be happy because it's going to cost twice as much or three times as much as it does right now. Out-of-pocket expenses have gone up 62 percent. Businesses increasingly are having to cut back on health care or—and if you talk to ordinary workers, they're seeing this all the time—employers, even if they don't want to, are having to pass on costs to others.

So unfortunately, whatever it is that we're doing right now isn't working, Diane. What we see is great examples of outstanding care, businesses that are working with their employees on prevention, but it's not spreading through the system. And unfortunately, Government, whether you like it or not, is going to already be involved. We pay for Medicare; we pay for Medicaid. There are a whole host of rules, both at the State and Federal level, governing how health care is administered.

And so the key is for us to try to figure out how do we take that involvement not to completely replace what we have but to build on what works and stop doing what doesn't work. And I think that we can do that through a serious health care reform initiative.

Mr. Gibson. But you say we have to figure out how to do that. Don't we have to do that first, "figure out," so people have a good sense that my medical care is going to be sufficient for me? That's what people are afraid of, that they're not going to get——

The President. Well, absolutely, people are afraid of it. People are concerned. They know that they're living with the devil, but the devil they know, they think, may be better than the devil they don't. And that's understandable. Look, every time we've made progress in this country on health care, there has been a vigorous debate. Senior citizens love Medicare now, but there was a big debate about whether we could set up Medicare. Children's Health Insurance Program, which provides millions of children health care across this country, that was a big debate.

So there's—these things are always going to be tough politically. Let me tell you, though, that we actually do know, in a lot of instances, what works and what doesn't. What's lacking is not knowledge. We've been debating this stuff for decades. What's lacking is political will. And that's what I'm hoping the American people provide, because genuine change generally does not come from Washington. Whether we like it or not, it comes from the American people saying, it's time for us to move forward. And I think this is that moment.

Primary Care Providers

Ms. Sawyer. And when we come back, Mr. President, from the break, we're going to be talking more about the centerpiece of this in many ways, primary care doctors and providers, and I'm going to turn to Hershaw Davis here, who's a nursing student and also an emergency tech at Johns Hopkins. Stand up, if you will. Because how bad is the shortage out there?

Q. It's bad, sir. Currently our patient load is increasing due to patients not having access either to insurance or primary care. And I want to ask, what's the administration going to do to place primary care providers—physician and nurse practitioners—back in the community so the ER is not America's source of primary care?

Mr. Gibson. All right, let's leave that question on the table.

Ms. Sawyer. On the table.

Mr. Gibson. We'll give you a second to think about the answer, and we'll take a commercial break. Be right back.

[*There was a break in the townhall meeting.*]

Mr. Gibson. Mr. President, before we went to break, Hershaw Davis raised what is an elemental question, which is, any kind of new system needs to be built around primary care and not all the specialists with all the tests, but primary care physicians who can then farm you out, in effect. So how do we reorient the system very quickly to get better primary care and more primary care?

The President. Well, first of all, we need more people like Hershaw who are going to school and committed to the kind of primary care that's going to be critical to us bringing down costs and improving quality. We're not going to be able to do it overnight. Obviously, training physicians, training nurse practitioners, that takes years of work. But what we can do immediately is start changing some of the incentives around what it takes to become a family physician.

Right now if you want to go into medicine, it is much more lucrative for you to go into a specialty. Now, we want terrific specialists, and one of the great things about the American medical system is we have wonderful specialists and they do extraordinary work. But, increasingly, medical students are having to make decisions based on the fact that they're coming out with $200,000 worth of loans. And if they become a primary care physician, oftentimes they are going to make substantially less money, and it's going to be much harder for them to repay their loans.

So what we've done in the Recovery Act, we started by seeing if we could provide additional incentives for people who wanted to go into primary care; some loan forgiveness programs, I think, are going to be very important. But what we're also going to have to do is start looking at Medicare reimbursements, Medicaid reimbursements, working with doctors, working with nurses to figure out how can we incentivize quality of care, a team approach to

care, that will help raise and elevate the profile of family care physicians and nurses as opposed to just the specialists who are typically going to make more money if they're getting paid fee-for-service.

Cost of Medical School

Mr. Gibson. Is Mary Vigil in the room? Mary Vigil. There you are. You're a medical student, right, coming out? And how much debt will you—can we get a microphone to Mary? How much debt will you have?

Q. I'll be in about $300,000 in medical education debt.

The President. That's serious money.

Mr. Gibson. And you would like to go into primary care?

Q. Definitely. That was my primary motivation in going into medical school.

Mr. Gibson. But you will—know you will be remunerated at a lesser level than a specialist.

Q. Yes.

The President. Right. And so one of the things that we've got to figure out is how to change that calculation. Now, you may still go into primary care, and I hope you do. But I don't want to make it tougher for you; I want to make it easier for you. And one of the things that I'd like to explore—and I've been working with the administration and with Congress is—are their loan forgiveness programs where people commit to a certain number of years of primary care. That reduces the costs for their medical education. That would make a significant difference.

Increasing the Number of Doctors and Nurses

Mr. Gibson. But let me ask a basic question, which may sound silly and naive. But we've got 46 million people who are uninsured in this country.

The President. Right.

Mr. Gibson. And one of your goals, one of the goals of health care reform is to get those 46 million people insured.

The President. Right.

Mr. Gibson. We only have X number of doctors in the country. If you add 46 million people to the insurance rolls—you can't get an appointment now, Mr. President—how are you going to get an appointment then, when there's 46 more million people competing for that doctor's time?

The President. Well, this is going to be a significant issue. First of all, I think it's important that whatever we do, we're going to phase it in; it's not going to happen overnight.

If we provide the right incentives I think we're going to start seeing more young people say that going into medicine is a satisfying, fulfilling profession, especially if we can eliminate some of the paperwork and bureaucracy that they have to deal with right now. And I don't—I have a lot of friends who are doctors, and they complain to me all the time about the administrative and business sides of the practice, when they actually got into medicine because they wanted to heal people.

But I also think that one of the big potential areas where we can make progress is what Hershaw talked about, and that is, how can we get nurses involved in more effective ways? If

you look at what's happening in some States, like Massachusetts, where they tried to create a universal system—and they haven't quite gotten there yet—they have had a problem with an overload of patients.

But one of the areas where we can potentially see some savings is a lot of those patients are being seen in the emergency room anyway, and if we are increasing prevention, if we are increasing wellness programs, we're reducing the amount of emergency room care; then that frees up doctors and resources to provide the kind of primary care that will keep people healthier, but also allow them to see more patients and, hopefully, give more time to patients as well.

Individual Health Care Decisions

Ms. Sawyer. I want to turn to someone who thinks we should follow up on what we were talking about a while back, namely about in some way reducing the vicious cycle of lots of tests, lots of treatment, what's necessary, what isn't necessary, and saying that somebody has got to enforce this; it's not going to happen if somebody doesn't. And by the way, he is James Rohack, from Texas, and he is president of the AMA, the American Medical Association.

Q. Thank you. Mr. President, clearly, when you spoke to us last week, you said that we entered the medical profession not to be bean-counters, not to be paper-pushers, but to be healers. And we totally agree. How are you going to assure the American public that medical decisions will still be between the patient and the physician, and not some bureaucracy that will make decisions on cost and not really what the patient needs?

Mr. Gibson. Once again, we'll leave that question on the table.

The President. All right.

Mr. Gibson. You answer it when we come back from commercial break. "Prescription for America" will continue.

[*There was a break in the townhall meeting.*]

Mr. Gibson. So, Mr. President, you remember the question?

The President. I do.

Well, first of all, I want to thank the American Medical Association. I did appear before them just last week in Chicago, my hometown, and had a terrific exchange of ideas, and we're continuing to work with all stakeholders, doctors, nurses, insurers, you—and, obviously, patients. You name it, folks out there are interested in seeing this happen.

The most important thing I can say, James, on this issue is, if you are happy with your plan and you are happy with your doctor, then we don't want you to have to change. In fact, if we don't do anything, if there's inaction, I think that's where the great danger that you lose your health care exists, because of the cost problems that I already talked about.

So what we're saying is, if you are happy with your plan and your doctor, you stick with it. If you don't have insurance, if it's too much for you to afford, if your employer doesn't provide it or you're self-employed, then we will have what's called an exchange, but you can also think of it as a marketplace, where essentially people can compare and look at what options are out there. They'll have a host of different health care plans available, each with their own physicians network, and you will be able to sign up for the plan that works for you.

We will help people who don't have insurance get insurance. Doctors are not going to be working for the Government. They're still going to be working for themselves. They're still going to be focused on patient care. And in terms of how doctors are reimbursed, it's going to be the same system that we have now, except we can start making some changes so that, for example, we're rewarding quality of outcomes rather than the number of procedures that are done.

And this is true not just for doctors, it's also true for hospitals. One of the things that we could say to hospitals is reduce your readmission rate, which is also often a sign that health outcomes have not been so good. And it turns out that hospitals, when they're incentivized, actually can find ways to do it that every study shows does not have adverse effects on outcomes.

Mr. Gibson. You keep coming back to that point about if you like what you have, you can keep it.

The President. Right.

Health Care for the Elderly

Mr. Gibson. And I will return to that subject when we get to the issue of the public option and whether the Government should be in the insuring business. But one of the things, when you talk about the kinds of changes that may occur, the elderly are affected. Medicare will be affected. Twenty-eight percent—26, 28 percent of money in Medicare is spent in the last year of life. The elderly are very critically affected. Just a quick sound bite from a couple of people to lay out the parameters of the problem.

[*A video was shown.*]

Ms. Sawyer. And we have with us a couple of people who really represents the opposite ends on this spectrum too. I want to talk, if I can, to Jane Sturm. Your mother, Hazel Homer——

Q. Yes.

Ms. Sawyer. A hundred years old, and she wanted——

Q. She's 105 now, over 105. But at 100, the doctor had said to her, "I can't do anything more unless you have a pacemaker." I said go for it; she said go for it. But the arrhythmia specialist said, "No, it's too old." Her doctor said, "I'm going to make an appointment, because a picture is worth a thousand words." And when the other arrhythmia specialist saw her, saw her joy of life and so on, he said, "I'm going forward." So that was over 5 years ago. My question to you is, outside the medical criteria for prolonging life for somebody who is old, elderly, is there any consideration that can be given for a certain spirit, a certain joy of living, a quality of life? Or is it just a medical cutoff at a certain age?

The President. Well, first of all, I want to meet your mom. [*Laughter*] And I want to find out what she's eating. [*Laughter*]

But, look, the first thing for all of us to understand is that we actually have some choices to make about how we want to deal with our own end-of-life care. And that's one of the things, I think, that we can all promote. And this is not a big Government program. This is something that each of us individually can do, is to draft and sign a living will so that we're very clear with our doctors about how we want to approach the end of life.

I don't think that we can make judgments based on people's spirit. That would be a pretty subjective decision to be making. I think we have to have rules that say that we are going to provide good, quality care for all people.

Mr. Gibson. But the money might not have been there for her pacemaker or for your grandmother's hip replacement.

The President. Well, and that's absolutely true. And end-of-life care is one of the most difficult, sets of decisions that we're going to have to make. I don't want bureaucracies making those decisions. But understand that those decisions are already being made in one way or another. If they're not being made under Medicare and Medicaid, they're being made by private insurers. We don't always make those decisions explicitly. We often make those decisions by just letting people run out of money or making the deductibles so high or the out-of-pocket expenses so onerous that they just can't afford the care.

And all we're suggesting—and we're not going to solve every difficult problem in terms of end-of-life care; a lot of that is going to have to be we as a culture and as a society starting to make better decisions within our own families and for ourselves. But what we can do is make sure that at least some of the waste that exists in the system that's not making anybody's mom better, that is loading up on additional tests or additional drugs that the evidence shows is not necessarily going to improve care, that at least we can let doctors know, and your mom know, that you know what, maybe this isn't going to help, maybe you're better off not having the surgery, but taking the painkiller.

And those kinds of decisions between doctors and patients, and making sure that our incentives are not preventing those good decisions and that the doctors and hospitals all are aligned for patient care, that's something we can achieve. We're not going to solve every single one of these very difficult decisions at end of life, and, ultimately, that's going to be between physicians and patients. But we can make real progress on this front if we work a little bit harder.

Ms. Sawyer. Is that a conversation you could have had with your mom? [*Laughter*]

Q. What I wanted to say was that the arrhythmia specialist who put the pacemaker in said that it cost Medicare $30,000 at the time. She had been in the hospital two or three times a month before that, so let's say 20, 30 times being in the hospital, maybe going to rehab. The cost was so much more, and that's what would have happened had she not had the pacemaker.

The President. Well, and that's a good example of where if we've got experts who are looking at this, and they are advising doctors across the board that the pacemaker may, ultimately, save money, then we potentially could have done that faster. I mean, this can cut both ways.

The point is we want to use science; we want doctors and medical experts to be making decisions that all too often right now are driven by skewed policies, by outdated means of reimbursement, or by insurance companies. And everybody's families, I think, have experienced this in one way or another. That's something—that's the reason we need reform right now.

Mr. Gibson. We're going to take one more commercial break, Mr. President. When we come back, we're going to get into the issue of whether or not in a reform measure there should be Government insurance for people, because a lot of people are very uncomfortable with that idea. "Prescription for America" continues.

[*There was a break in the townhall meeting.*]

Public Health Care Plan/Government Involvement in Health Care

Mr. Gibson. As I probably could have anticipated, this is running a little longer than we thought. The President has been nice enough to say he would stay during your local news, and we will continue this discussion during the "Nightline" half hour.

And so we're going to get into that public option and whether there should be the Government insurance as part of all of this. But I do want to get to cost, because as you know, the Congressional Budget Office is estimating that this is going to cost over the next 10 years 1 trillion to $2 trillion. There's all these estimates. And the question is, can we afford it? And there's a lot of people who have that question on their minds.

Ms. Sawyer. And bringing in Christopher Bean from Maryland.

Q. Good evening. It's a pleasure to be here and meet you.

The President. Thanks, Christopher.

Q. I do have kind of a two-base question. I'm going to read it, because I'm very nervous. [*Laughter*] In light of this proposed health care reform and national health care system, I have many concerns. One of them is the "Big Brother" fear: How far is Government going to go in reference to my personal life and health care treatments? And then secondly, how and who will pay for the national health care system?

The President. Good. Well, look, both are great questions. We've been sort of circling around your first question, the whole "Big Brother" fear. What kind of insurance, Chris, do you have right now? What kind of coverage do you have?

Q. It's a BlueCross BlueShield.

The President. It's a BlueCross BlueShield. So if you're happy with your plan, as I said, you keep it. Now, there are some restrictions we want to place on insurers. Preexisting conditions is a tool that has prevented a lot of people from either not being able to get insurance or, if they lose their job, they can't find insurance. We think those policies should end. So there are going to be some areas where we want to regulate the insurers a little more.

Now, in exchange, they're going to have a bigger customer pool. And so we think that they may not make as much profit on every single person that they provide coverage to. On the other hand, overall, I think they can still be profitable.

Now, in terms of cost, understand that the system is already out of whack in terms of costs as it is. So if we do nothing, costs are going to keep on going up 6, 7, 8 percent per year, and government, businesses, and families are all going to find themselves either losing their health care or paying a lot more out of pocket. That's going to happen if we do nothing.

What I've said is, let's change the system so that our overall cost curve starts going down by investing in a range of things: prevention, health IT, et cetera. We will have some upfront costs, and the estimates, as Charlie has said, have been anywhere from a trillion to $2 trillion. But what we've said is, what my administration has said, what I've said, is that whatever it is that we do, we pay for. So it doesn't add to our deficit.

Now, we've put forward some specific ways of paying for the health reform that we talked about. About two-thirds of the cost would be covered by reallocating dollars that are already in

the health care system; taxpayers are already paying for it, but it's not going to stuff that's making you healthier.

So a good example of that: We spend $177 billion over 10 years on providing subsidies to insurers. And if we can take that money and use it to help train young doctors for primary care, to provide more coverage, to improve prevention and wellness, that's a good way of spending money that we're already spending.

About a third of the costs will come from new revenue. And so what I've proposed is, is that we cap the itemized deductions that the top 2 or 3 percent get—people making over 250 a year, me and Charlie—so that our item—so that we're itemizing our deductions at the same level as most middle-class families are. With that additional money, we would have paid for all the health care that I'm proposing.

So there's a way of paying for this that doesn't add to the deficits. And the last point I'll make—it's a big question; I was trying to be quick, because Charlie is looking at his watch—[*laughter*]—the last point is, all this money that I just talked about, those are hard dollars. We know they are, and so we know that this would not add to the deficit.

It doesn't count all the savings that may come from prevention, may come from eliminating all the paperwork and bureaucracy because we've put forward health IT; it doesn't come from the evidence-based care and changes in reimbursement that I've already discussed about. And the reason is, is because the Congressional Budget Office, the CBO, which sort of polices what all various programs cost, they're not willing to credit us with those savings. They say, that may be nice, that may save a lot of money, but we can't be certain.

So we expect that not only are we going to be able to pay for health care reform in a deficit-neutral way, but that it's also going to achieve big savings across the system, including in the private sector, where the Congressional Budget Office never gives us any credit. But if hospitals and doctors are starting to operate in a smarter way, that's going to help you, even if you're not involved in a Government system. That's how we can end up achieving costs. But it requires all of us making some upfront investments, and I think we can find a bipartisan way to do that.

Ms. Sawyer. Mr. President, we're going to take a break, come back with a lot more questions about whether the Government should be involved in all of this, who is going to be covered, and how. We'll be back.

[*There was a break in the townhall meeting.*]

Paying for Health Care Reforms

Ms. Sawyer. ——question from Dr. Gail Wilensky, who ran Medicare in the Bush administration. Your question?

Q. I want to go back to how we pay for the expansions. Estimates, as you indicated, probably $1½ trillion to cover everyone. You mentioned savings on Medicare and Medicaid, five to six hundred billion from the numbers you've provided, another 300 billion from additional revenue. That leaves about 300 to 600 billion more. What do we do in ways that CBO will count so that we can actually get everybody covered?

Mr. Gibson. And run that down in about 30 seconds. [*Laughter*]

The President. Well, look, that's the challenge. And obviously, there's a vigorous debate taking place. There are a whole host of ideas, some that cut across parties. There are people

who think that we should tax benefits—health care benefits at a certain level, cap the deduction. There are others who proposed a surcharge on high-income individuals. There are other cuts that may be obtained that, ultimately, we could find scorable.

Here's my general point, because I know that we're starting to wrap up: This is not an easy problem, and it's especially not an easy problem when the economy is going through a difficult phase. We've taken a body blow to the economy, and families were oftentimes hurting even before then.

But the one thing I'm absolutely confident about is that whenever this country has met a significant challenge to our long-term well-being, that we, ultimately, rise up and meet it. And this is one of those moments where the stars are aligned. We've got insurers who are interested, doctors who are interested, nurses, patients. AARP is here, and they've seen some of the potential benefits. We're actually going to be filling the "doughnut hole"; drug companies have said that they'd be willing to reduce the costs for seniors for prescription drugs as part of health care reform.

But we have to have the courage and the willingness to cooperate and compromise in order to make this happen. And if we do, it's not going to be a completely smooth ride. There are going to be times over the next several months where we think health care is dead, it's not going to happen. But if we keep our eye on the prize, and that we recognize that America has always been up to these big challenges, and we can't afford not to act, then I'm absolutely convinced that we can get it done this time.

Mr. Gibson. So that concludes our prime-time special, "Prescription for America," but your local news is coming up next. And we hope you'll stay with us; the President is going to stay with us, our audience stays with us, and we will have more questions for him about health care reform during the "Nightline" half-hour.

[*There was a break in the townhall meeting.*]

Public Health Care Plan/Government Involvement in Health Care

Mr. Gibson. And we welcome you to this special edition of "Nightline." Just to tell you where we are, we're in the East Room of the White House with the President and 164 invited guests here who represent all different perspectives on the subject of health care reform. And we have questions for the President—call this "Prescription for America." We had an hour there on prime time earlier before your local news, but the President is going to stay with us, and we have more questions, and there are some critical things that we did not get to in that hour. Most critically of all, in talking about health care reform, there's the very controversial subject of whether there needs to be a public option, whether there needs to be Government-run insurance as one of the options to get more people insured and for the general nature of health care reform.

Your critics on the Republican side of the Senate Finance Committee wrote you a letter and said, "At a time when major Government programs like Medicare and Medicaid are already on a path to fiscal insolvency, creating a brand new program will not only worsen our long-term financial outlook, but also negatively impact American families who enjoy private coverage for their insurance." What do you say to them?

The President. They're wrong. [*Laughter*] And so let's just explain, as clearly as possible, what we're talking about. What we want to do, as I said before, was set up a health care exchange, or a marketplace, essentially giving the American people the same kind of options

that Members of Congress do or Federal employees do. You—there is a range of options that are available. Private insurers will participate. You will be able to do some one-stop shopping and compare all the different plans, what kind of benefits they provide, what are the deductibles, figure out what's best for you.

Now, what we've said is, as one option among multiple options should be a public option, where we set up a insurer that isn't profit-driven, that can keep administrative costs low, and that can serve as competition to the private insurers. Now, what—the argument that's been made has been that somehow the public option will crowd out private insurers.

Mr. Gibson. It's not a level playing field.

The President. And that's the argument, that it's not a level playing field. And what we've said is, it wouldn't be a level playing field if the Government can just print money and subsidize that public plan so that premiums are a lot lower than costs and doctors are getting reimbursed a lot lower than they do in the private sector. Well, that's true. It also wouldn't be a very good plan.

But what we've said is that we can set up a public option in which they're collecting premiums just like any private insurer, that doctors are reimbursed at a fair rate, but because administrative costs are lower, we are able to keep private insurers honest in terms of the growth of costs of premiums and deductibles and so forth.

Now, you'll always hear folks say that the free market can do it better; Government can't run anything. And what I say is, well, if that's the case, nobody is going to choose the public option. So the private insurers, who I think are very confident that they're providing a good service and a good product to their customers, should feel confident that they can compete with just one other option.

A lot of the objection to the public option idea is not practical; it's ideological. People don't like the idea of Government being involved. But keep in mind that the two areas where Government is involved—are involved in health care—Medicare and the VA—actually, there's pretty high satisfaction among the people who participate.

Private Sector Health Insurance

Mr. Gibson. Well, Diane is here with the head of a major insurance company.

Ms. Sawyer. If I could, I'm going to bring in Ron Williams from Aetna, CEO of Aetna. And if I can reverse the order a little bit, Mr. President, I'd like to ask a question of him, and then let you come in on his answer.

The President. Absolutely.

Ms. Sawyer. Mr. Williams, Aetna, to take one—an insurance company—we hear all over the country, people see their premiums going up 119 percent in the last several years; they see the profits of the insurance companies in the billions and billions of dollars. Even in a lean year, they see profits in the billions of dollars. Is the President right that you need to be kept honest?

Q. Well, I would first say, I would commend the President for the commitment he's made to really try to get and keep everyone covered. And I think, as a health insurance company, we're committed to that.

In the context of the question that you ask, I think that it's difficult to compete against a player who is also the person who is refereeing the game. And so I think in the context of thinking about a Government plan, what we say is, let's identify the problem we're trying to solve; let's work collaboratively with physicians, hospitals, and other health care professionals and make certain that we solve the problem, as opposed to introduce a new competitor who has the rule-making ability that Government would have.

Ms. Sawyer. Mr. President?

The President. Well, I think that—first of all, I want to say that Mr. Walters [Williams]* has been very cooperative. We've been having a series of conversations, and I appreciate the constructive manner in which we've been trying to work together. But I just want to make clear that the Government, whatever rules it provides to insurers, a public plan would have to abide by those same rules. So we're not talking about an unlevel playing—unequal playing field; we're talking about a level playing field.

I also want to point out that one of the incentives for private insurers to get involved in this process is that potentially they're going to have a whole bunch of new customers, paying customers. And if we are, as part of health care reform, going to go forward in providing additional coverage to people who either don't have health insurance or who are underinsured—and that's a lot of working people, I just want to be clear. These are people who are working every day and are still finding themselves having a great deal of trouble and oftentimes collecting huge amounts of debt. If we're going to give all these new customers to the insurance industry, one of the things that we should say is, in return, that we change some of our practices and at least have some competition so that, for example, you can't eliminate people for preexisting conditions; you can't cherry-pick just the healthiest folks. And a public option is one tool by which we can do this.

And I think that the insurance companies will still thrive. They've got terrific leadership. Aetna is a well-managed company, and I'm confident that your shareholders are going to do well.

Private Sector Health Insurance vs. Public Health Plan

Mr. Gibson. Mr. President, there is a lot of doubts about this as to whether it's a level playing field. The Lewin Group studied this. There's 177 million people in this country with private insurance through their employers. That group estimates, with Government insurance, that employers will go to that because it will be cheaper, and they estimate—the head of the Lewin Group, I believe, is here, Mr. Shiels—they estimated that two-thirds of people would go to the private—would go to the public insurance option. Let me get you a microphone. Can we get him a microphone, please? Thank you.

Q. Well, we looked at several different options. You could design it in several different ways. There was a particular scenario that people looked at, and that's what got all the attention. It's one where the premiums would be, for a family, for example, would be as much as $2,500 a year less than in the private market. The reason for it is that they paid under—they used the Medicare payment reimbursement methodology. And they pay physicians a lot less, hospitals a lot less.

* White House correction.

So the premium came out to as much as $2,500 a family lower in that particular scenario. That's pretty attractive. We estimate that 70 percent of anybody with private insurance would make the shift to the public plan.

Mr. Gibson. Which would be millions of people going over to public insurance. You keep saying, if you have what you like, you can keep it. But if your employer goes over to the Government program, maybe you can't keep what you have.

The President. Well, first of all, I think it's important to understand, and I think the Lewin Group acknowledges this, that there are a whole series of ways that we could design this. One of the things that we've said is that if you are eligible for your employer plan, then you can't just go into the public plan. You can't decide that you're already having a pretty good deal in insurance and you're just going to dump that—what's called a firewall.

The other thing we're doing is we're saying to employers, to provide them a disincentive for just dumping people out of existing plans, is there's going to be a "pay or play" provision. If you're not providing health insurance to your employees and you're a large employer, you're going to have to kick in a certain amount of money, because it's not fair for taxpayers to have to cover your employees, whether it's through a public plan or through uncompensated care, essentially sending people to the emergency room, which, by the way, adds to all of our premiums collectively about a thousand bucks a year.

So we would—I think there are some legitimate questions in terms of how the public option is designed. One thing I have to say, though, is it's not an entirely bad thing if—as long as they're reimbursing doctors in a adequate way, and so not being oppressive on health care providers, and as long as there are not a whole bunch of taxpayer subsidies going into a public plan. If the public plan can do it cheaper and provides good quality care, that's the competition that we talked about. I don't think you're going to get a lot of complaints from people if this—the deal is a better deal. If it's not a better deal, then people aren't going to choose it. But what we think is, is that we can set up a system in which you are expanding choices for individuals as opposed to constricting them.

Mr. Gibson. All right. We'll take a commercial break. "Nightline" will continue. Stay with us. More questions for the President.

[*There was a break in the townhall meeting.*]

Medicare and Medicaid

Mr. Gibson. And we're back. Our special edition of "Nightline" continues.

Mr. President, on this issue of cost of this entire thing, a lot of people are concerned that it's going to be so expensive, their taxes are going to go up. And we have a question on that very subject. Is David Hattenfield here?

Ms. Sawyer. Yes.

Mr. Gibson. David, where are you? Stand up.

Ms. Sawyer. Right here.

Q. Yes, I guess, the—first of all, I'd like to just say it is good to be here this evening.

The President. Thank you, David.

Q. With the cost of health care, I'm pretty satisfied with my own plan. It's not everything that it should be or could be, but I am concerned that—of the Government taking over health care, and, you know, Social Security isn't doing real well, at least that's what we're being told, and how can we know that the Government is going to be able to handle the cost of health care? Isn't that going to tax me? Isn't it going to be taxing my benefits? Those kind of things.

The President. Right. Well, look, I think it's a very legitimate question. I guess I—the first point I'd make is, if we don't do anything, costs are going to go out of control. Nobody disputes this. Medicare and Medicaid are the single biggest drivers of the Federal deficit and the Federal debt by a huge margin. And at the pace at which they're going up, if we don't do some of the things that we've talked about tonight—changing how we pay for quality instead of quantity, making sure that we are investing in prevention, all those game-changers that I discussed earlier—if we don't do those things, Medicare and Medicaid are going to be broke, and it will consume all of the Federal budget. Every program that currently exists under the Federal budget, except defense and entitlements, all that would be swept aside by the cost of health care if we do nothing.

So that's point number one. Point number two is that a lot of what we're talking about is reallocating existing health care dollars that are not being spent wisely. And almost everybody agrees that there is a lot of room for us to improve how we're spending existing health care dollars.

And point number three, there is going to be a need, initially, for some additional revenue. And I talked about our suggestion, my administration's suggestion, the best way to do that: capping itemized deductions for people making over $250,000 a year.

But I also believe that if we are doing this right, and we're bending the curve on health care, then you, who keeps a private plan, will see reductions in your out-of-pocket costs over time, so that instead of your health care premiums going up three times your wages over the next decade, it may only go up by the amount that inflation goes up generally. And that's real money in your pocket. That's real savings that would offset any potential increases.

By the way, I suspect that Charlie and I—again, 2, 3 percent of the population—we're the ones who would see our taxes go up a little bit to pay for that initial outlay.

Taxing Health Care Benefits

Mr. Gibson. But let me—on this tax question, let me get to this issue of taxing health care benefits. It isn't—there is a massive amount of money that employers pay for health care benefits, and it is not taxed, for me or you or anybody else in this room. You went after John McCain when he suggested taxing that money, that we would have to pay taxes on that.

The President. Right.

Mr. Gibson. Should we pay taxes on that? A lot of people question whether there's enough money to pay for all this. Are you willing to entertain the idea of taxing health care benefits?

The President. Well, I continue to strongly disagree with John McCain's plan that he presented during the campaign, which was to eliminate the deduction—let me finish——

Mr. Gibson. But you went after him for suggesting that we tax that money.

The President. I'm about to answer your question, Charlie.

Mr. Gibson. Okay, good. [*Laughter*]

The President. I continue to believe that it would be the wrong way to go, for us to eliminate the deduction or the exclusion on health care benefits that essentially taxes current benefits. What's being discussed in Congress right now is capping those—that deduction or that exclusion at a certain level.

I continue to believe that's not the best way to do it, because I think that what you would see—certainly if you eliminated it completely, essentially employers would stop providing health insurance, and then we would really have to have either a public plan or what John McCain was proposing, everybody just gets that money back in wages and then—or tax credits—and you go out and you shop by yourself. The problem is that the amount of money you're getting back is not going to be the same as the costs of an average insurance plan, especially if you're not in a pool.

What's being—that's not what's being discussed right now in Congress. They're saying, at a certain level, whether it's 13,000 or $17,000 a year, which is what they consider to be a high-end or a Cadillac plan, maybe your deduction would phase out. I continue to believe that the better way for us to fund this is through the capping of the itemized deduction.

But I think there are people, in good faith, who are saying a cap would at least prevent these Cadillac plans that end up having people overutilizing the system. That's a debate that's taking place in Congress right now. I'm pushing my idea. Other folks are pushing their ideas. There's going to have to be some compromise at the end of the day.

Mr. Gibson. All right, Mr. President, we'll take another break. "Nightline" continues. Stay with us.

[*There was a break in the townhall meeting.*]

Health Care Systems in Other Countries vs. America's Health Care System

Ms. Sawyer. More quick questions, if we can here. Charlie, Marisa Milton—skeptical.

Q. A little skeptical on cost, Mr. President. Other industrialized nations provide coverage for all of their residents. They have higher quality care, and they do so spending about less than half of what we spend on health care now. So there's an argument that could be made that we actually don't need to spend any new money to fix the system if we're willing to make some tough decisions. Could you comment on that and maybe exploring that as an approach?

The President. Well, you're absolutely right that we spend at least 50 percent more than any other advanced country, and we don't have better outcomes in terms of infant mortality, longevity, all those various measures of wellness.

Now, a lot of those other countries employ a different system than we do. Not all of them, by the way, use a socialized medicine, as I think the British National Health Services is called. Some of them have what would be considered—almost all of them have what would be considered a single-payer system in which the government essentially operates a Medicare for all, even though doctors and health care providers are still separate.

The problem is, is that we have a employer-based system that has grown up over decades. For us to completely change our system, root and branch, would be hugely disruptive and, I think, would end up resulting in people having to completely change their doctors, their health care providers, in a way that I'm not prepared to go. This is one-sixth of our economy. I think that we can build on what works, fix what's broken, and still save substantial money.

Helping the Uninsured

Ms. Sawyer. Gary Cloutier, who is a body shop owner.

Q. Yes, body shop owner from Westfield, Massachusetts. Cloots Auto Body—got to give myself a plug.

The President. There you go. [*Laughter*]

Q. Okay. And I don't have insurance. I'm one of those 46 million that has none at all. Under Massachusetts policy, I make too much money, and I don't qualify. So I'm on the outside looking in. What are you going to do for people like me so that we don't fall through the cracks and we're able to get insurance like everybody else?

The President. Well, I think the self-employed are a huge example. And that's a growing part of our population, and that's a huge portion of the people who are having a very difficult time getting health insurance, partly because if you're not part of a big pool, you just can't get a good deal. It ends up being really expensive.

That's why we want to set up these exchanges, because for a person like you who is self-employed, doesn't have health insurance, for you to be part of this exchange, this marketplace, along with millions of others, suddenly you've got a little bit of market clout. Private insurers are going to want your business, and that means that you can negotiate for a better price. If we've got a public option in there, then that's also an alternative. And one of the things that we're going to need to do is to provide some subsidies for folks who just can't afford it, even when the option is provided to them.

That's where some of the new money is going to come in, is to make sure that people who don't have health insurance are able to get it without taking on huge amounts of debt.

Mr. Gibson. Dr. Tim Johnson, our medical editor. We started this with you outlining the parameters of this. Observation?

Training Health Care Workers/Health Care for the Elderly

Dr. Johnson. Observation would be, if you're successful in getting rid of some of that 30 percent of unnecessary care, you're going to dislocate a lot of people. Now, some of them are criminals committing fraud, and they ought to go to jail, but a lot of them are real people with real jobs. Why not, right now, start talking about retraining these people for primary care jobs: nurse practitioners, physician assistants? I hear no talk about that.

The President. Well, I think you make a reasonable point that if you're going to change this health care system over time, then, to be very specific, the amount of person power that goes into billing, administration, all the things that we hate about the health care system—even though those are wonderful people who are doing great work—they're over time, hopefully, going to be moving into the actually providing care side of the health care industry, as opposed to the bean-counting side of the health care industry.

Keep in mind, though, that this is—our goal here is to over time change the system, over time reduce costs, over time transition those folks into the health care side of it. We already mentioned that we still have a nurse shortage out there. We still have a shortage of people who are providing primary care. People who are already in the health care system, I think, naturally would gravitate towards that.

And the last point I would make is we've got an aging population, so we know that health care is still going to be a growth industry. And that's not an entirely bad thing. As societies get older, we spend a certain larger portion of our overall income on health care, and that's okay.

We just don't want to spend it badly and in a way that bankrupts the entire economy, and that's why we need the changes that I've discussed.

Mr. Gibson. Mr. President, I want to thank you for joining us this evening, both for the earlier hour and for this half-hour of "Nightline." As we mentioned at the beginning, I think this is a topic that is going to be discussed in every living room, over every kitchen table—not only in the Congress, but mostly in the living rooms and in the kitchens of America. And that probably is where the decisions overall will be made: Can we support this? Are we for this? Are we certain that we'll have the care we need? And are we certain that this country can pay for it at a time when we don't have a lot of money.

The President. The answers are "yes" to all of that, and if the American people get behind this, this is going to happen.

Mr. Gibson. All right, Mr. President, I thank you for being with us. Thanks very much.

The President. Thank you so much. I've enjoyed it.

NOTE: The President spoke at 8:01 p.m. in the East Room at the White House. In his remarks, he referred to Diane Sawyer, anchor, ABC's "Good Morning America"; Charles Gibson, anchor, ABC's "World News with Charles Gibson"; Orrin Devinsky, professor of neurology, neurosurgery, and psychiatry, New York University Medical School; John Corboy, professor of neurology, University of Colorado Health Sciences Center; Christopher D. Bean, material specialist, Allint Techsystems, Inc.; David Hattenfield, senior pastor, Cornerstone Baptist Church in Cumberland, MD; and Sen, John McCain of Arizona, 2008 Republican Presidential candidate. Mr. Gibson referred to John Sheils, senior vice president, The Lewin Group. Ms. Sawyer referred to Gail R. Wilensky, former Administrator, Health Care Financing Administration; and Marisa L. Milton, vice president for health care policy and government relations, HR Policy Association. The transcript was released by the Office of the Press Secretary on June 25. A portion of these remarks could not be verified because the tape was incomplete.

Categories: Addresses and Remarks : ABC's "Prescription for America" townhall meeting.

Locations: Washington, DC.

Names: Bean, Christopher D.; Corboy, John; Davis, Hershaw, Jr.; Devinksy, Orrin; Devinsky, Orrin; Gibson, Charles; Hattenfield, David; Homer, Hazel; Johnson, G. Tim; McCain, John; Obama, Malia; Obama, Michelle; Obama, Natasha "Sasha"; Rohack, J. James; Sawyer, Diane; Williams, Ronald A.

Subjects: AARP; ABC : "Prescription for America" townhall meeting; Budget, Federal : Deficit; Budget, Federal : National debt; Business and industry : Preventive health and wellness, employer-based incentives; Economy, national : American Recovery and Reinvestment Act of 2009; Economy, national : Recession, effects; Education : Postsecondary education :: Medical school costs; Health and Human Services, Department of : State Children's Health Insurance Program (SCHIP); Health and medical care : Cost control reforms; Health and medical care : Employer-based health insurance coverage; Health and medical care : End-of-life care; Health and medical care : Health Insurance Exchange, proposed; Health and medical care : Information technology; Health and medical care : Insurance coverage and access to providers; Health and medical care : Living wills; Health and medical care : Medicare and Medicaid; Health and medical care : Nurse remuneration and education; Health and medical care :

Physicians :: Medicare and Medicaid reimbursement; Health and medical care : Prescription drugs, purchasing efficiency; Health and medical care : Preventive care and public health programs; Health and medical care : Primary care physicians, shortages; Medical Association, American; Taxation : Itemized health care deductions; Veterans : Health care.

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